AFFILIATED THERAPY GROUP PRACTICE, INC.

PATIENT INFORMATION
(Please Complete All Items)

Thank you for choosing our office.
In order to serve you properly we will need the following information. (**Please print**). All information will be strictly confidential.

PATIENT INFORMATION

DATE:

PATIENT'S NAME ❒ MALE ❒ FEMALE MARITAL STATUS S M W D SEP	DATE OF BIRTH	AGE	SOCIAL SECURITY NO.	DRIVER'S LICENSE NO & STATE
PATIENT ADDRESS ❒ PERMANENT ❒ TEMPORARY	CITY & STATE		ZIP CODE	HOME PHONE NO.
PATIENT EMPLOYER				BUSINESS PHONE NO.
EMPLOYER'S ADDRESS				
SPOUSE'S NAME (IF NOT, RESPONSIBLE PARTY)	DATE OF BIRTH	AGE		SOCIAL SECURITY NO.
ADDRESS (IF DIFFERENT THAN PATIENT)	CITY & STATE			ZIP CODE
SPOUSE'S EMPLOYER	HOME PHONE NO.			BUSINESS PHONE NO.
NAME & ADDRESS OF SOMEONE TO NOTIFY (IN CASE OF EMERGENCY OTHER THAN SPOUSE)	RELATIONSHIP			PHONE NO.

INSURANCE INFORMATION

WAS THIS INJURY DUE TO AN AUTO ACCIDENT?_____ DATE OF ACCIDENT:_____

PRIMARY INSURANCE CO.		SECONDARY INSURANCE CO.	
COMPLETE ADDRESS		COMPLETE ADDRESS	
FULL NAME OF INSURED	DATE OF BIRTH	FULL NAME OF INSURED	DATE OF BIRTH
POLICY / CONTRACT NO.	GROUP NO.	POLICY / CONTRACT NO.	GROUP NO.
THROUGH WHAT EMPLOYER	SOCIAL SECURITY NO.	THROUGH WHAT EMPLOYER	SOCIAL SECURITY NO.

WORKER'S COMPENSATION

INSURANCE CARRIER	DATE OF ACCIDENT	CLM#
COMPLETE ADDRESS	ADJUSTOR'S NAME	PHONE NO.

GENERAL FINANCIAL INFORMATION

PERSON FINANCIALLY RESPONSIBLE (OTHER THAN PATIENT)	RELATIONSHIP	HOME PHONE NO.
ADDRESS	CITY & STATE	ZIP CODE
EMPLOYER	OCCUPATION	BUSINESS PHONE NO.
BUSINESS ADDRESS	CITY & STATE	ZIP CODE

REFERRING PHYSICIAN

NAME	NEXT DOCTOR'S APPOINTMENT DATE	TIME

PLEASE SEE BACK

AUTHORIZATION TO RELEASE OR RECEIVE MEDICAL INFORMATION
and
AUTHORIZATION OF ASSIGNMENT OF BENEFITS

We strongly feel that all patients deserve from us the very best medical care that we can provide. Further, we feel that everyone benefits when definitive financial arrangements are agreed upon. Accordingly, we have prepared this material to acquaint you with our policy.

Our professional services are rendered to you, ***not the insurance company.*** Therefore, payment for treatment is your responsibility. Insurance benefits are verified at the time of your visit and are ***not a guarantee of payment.***

Please read and sign the following:

1) I authorize this office to release or receive any information necessary to expedite insurance claims.
2) I hereby authorize this office to bill my insurance company directly for their services.
3) I authorize payment directly to this clinic of any insurance benefits otherwise payable to me.
4) In the event I receive payment from my insurance carrier, I agree to endorse any payment I receive over to my therapist for which these fees are payable.
5) If you are a worker's compensation patient, your worker's compensation carrier is responsible.
6) If your employer is self insured, you will be responsible for any remaining balance.

I understand that I am directly and fully financially responsible to this clinic for charges not covered by my insurance. I further understand that such payment is not contingent on any settlement, judgement or insurance payment by which I eventually recover said fee. I realize that if my insurance fails to pay my balance in full, or there is no payment made within 60 days, it is my responsibility to pay my therapy bill directly.

I further understand and agree, that if I fail to make timely payments on my account, I will be responsible for any and all reasonable costs of collection, including filing fees as well as reasonable attorney's fees.

There will be a $25.00 charge on all returned checks.

A photostatic copy of these authorizations and agreements shall be as valid as the original.

I acknowledge that no guarantees have been made as to the results of medical treatment hereby authorized.

I understand that I am fully responsible for all articles (money, radios, jewelry, dentures, eyeglasses, etc.) and clothing which I retain in my possession.

I hereby authorize Affiliated Therapy Group Practice, Inc. to carry out all procedures ordered by my physician and I give you my consent for treatment.

I have been offered a paper copy of the "Notice of Privacy Practices" during the admission/registration process. _____ Intials

Signature / Parent's Signature if Minor_____

Date_____

PLEASE PRESENT BOTH YOUR INSURANCE CARD AND YOUR DRIVER'S LICENSE SO WE MAY MAKE A COPY FOR OUR RECORDS.

CONSENT TO TREAT A MINOR

I, _____ will not be present for my son/daughter's
(Parent or Legal Guardian Name)

therapy treatment. I hereby give Affiliated Therapy Group Practice, Inc. permission

to treat _____.
(Patient Name)

In the event of unforeseen circumstances, I can be reached at _____.

_____ _____
(Parent or Legal Guardian Signature) (Date)

AFFILIATED THERAPY GROUP PRACTICE, INC.

*"See a Therapist you trust...So you can **TRUST** the therapist you see"*

Outpatient Information Form

Your Name: _____ Date: _____

Please Check any of the following you have seen for this condition:

( ) MD ( ) DO ( ) DC ( ) DDS ( ) DPM ( ) PT ( ) OT ( ) Psychologist

Surgeries / Procedures: _____

Have you had any injections for this condition? ( ) Yes ( ) No When? _____ Did it help? ( ) Yes ( ) No

Have you been diagnosed with or suffer from the following?

☐ Infectious Diseases: (TB, HIV or Hepatitis)	☐ Epilepsy / Seizures	☐ Kidney Problems	☐ Tendon Repair	☐ Low Back Pain
	☐ Stroke	☐ Cancer	☐ Fractures	☐ Thyroid Problems
☐ Heart Disease	☐ Respiratory Failure	☐ Closed Head Injury	☐ Knee Weakness	☐ Osteoporosis
☐ Hypertension	☐ Stomach Problems	☐ End Stage Renal Disease	☐ Tendonitis / CTD / CTS	☐ Cognitive Problems
☐ COPD	☐ Multiple Sclerosis	☐ Psychological Issues	☐ Shoulder Pain	☐ Blood Disorders
☐ CHF	☐ Diabetes	☐ Depression	☐ Arthritis _____	
☐ Lung Problems	☐ Neuropathy	☐ Obesity	☐ Amputations	
☐ Coronary Artery	☐ Vascular Disease	☐ Allergies	☐ Neck Pain	

☐ Other _____

Do you have any allergies to medicines? _____

Please List All Medications Including Over-the-Counter Medications and Home Remedies

Name of Drug	Dose / Amount	Frequency	Comments

What diagnostic tests have you had & results? _____

Are you currently working? YES NO If yes, how much? ( ) Full Duty ( ) Restricted Duty

What are your job responsibilities? _____

How many work/school days have you missed? _____

What critical work duties/tasks have been affected by your injury/condition? _____

What do you want to accomplish with your therapy? _____

The above information has been reviewed with the patient and therapist.

Patient Signature: _____ **Date:** _____

Therapist Signature: _____ **Date:** _____

If you have any questions, please contact our office at the address or phone number on this Notice.

WHO WILL FOLLOW THIS NOTICE?

AFFILIATED ThERAPY GROUP PRACTICE, INC. provides health care to our patients and clients in partnership with physicians and other professionals and organizations. The information privacy practices in the Notice will be followed by:

- Any health care professionals who treats you at our facility;
- All departments and units of our organization;
- All employed associates, staff or volunteers of our organization with whom we may share information as permitted within our organized health care arrangement;
- Any business associate or partner of Affiliated Therapy Group Practice, Inc. with whom we share health information.

OUR PLEDGE TO YOU.

We understand that medical and billing information about you is personal. We are committed to protecting the privacy of your medical and billing information. We create a designated record of the care and services you receive to provide quality care and to comply with legal requirements. This Notice applies to all of the records of your care that we maintain, whether created by facility staff or your personal doctor. Your personal doctor may have different policies or Notices regarding the doctor's use and disclosure of your medical and billing information created in the doctor's office. We are required by law to:

- Keep medical and billing information about you private;
- Give you this Notice of our legal duties and privacy practices with respect to your protected health information;
- Follow the terms of the Notice currently in effect.

AThGP

"see a THERAPIST you trust...

so you can TRUST the therapist you see"

AFFILIATED ThERAPY
GROUP PRACTICE, INC.

4738 South Padre Island Drive
Corpus Christi, Texas 78411

Phone: (361) 853-6100

Fax: (361) 853-6106

E-mail: info@athgp.com

NOTICE OF PRIVACY PRACTICES

Effective 10/1/2006

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

AThGP

AFFILIATED ThERAPY
GROUP PRACTICE, INC.

Phone (361) 853-6100

CHANGES TO THIS NOTICE

We may change our policies and privacy practices at any time. Changes will apply to your protected health information we already hold, as well as new information obtained after the change occurs. When we make a significant change in our policies, we will change our Notice and post the new Notice in waiting areas and on our Web site at www.info@athgp.com You can receive a copy of the current Notice at any time. The effective date is listed just below the title. You will be offered a copy of the current Notice each time you register at our facility for treatment. You will also be asked to acknowledge in writing your receipt of this Notice.

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

- We may use and disclose medical and billing information about you for treatment (such as sending medical information about you to a specialist as part of a referral); to obtain payment for treatment (such as sending billing information to your insurance company or Medicare); and to support our health care operations (such as comparing patient data to improve treatment methods).
- We may use or disclose medical and billing information about you without your prior authorization for several other reasons. Subject to certain requirements, we may give out protected health information about you without prior authorization for public health purposes, abuse or neglect reporting, health oversight audits or inspections, research studies, funeral arrangements, organ donation, workers' compensation purposes, or during emergencies. We may also disclose protected health information when required by law, such as in response to a request from law enforcement officials in specific circumstances, or in response to valid judicial or administrative orders.
- We may contact you for appointment reminders, or to tell you about or recommend possible treatment options, alternatives, health-related benefits or services that may be of interest to you.

OTHER USES OF MEDICAL INFORMATION

- In any other situation not covered by this Notice, we will ask for your written authorization before using or disclosing your protected health information. If you choose to authorize our use or disclosure of your protected health information, you can later revoke that authorization by notifying us in writing of your decision.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

- In most cases, you have the right to look at or obtain a copy of medical and billing information contained in the designated record set that we use to make decisions about your care. If you request copies, we may charge a fee for the cost of copying, related supplies or postage. If we deny your request to review or obtain a copy, you may submit a written request for a review of that decision.
- If you believe that information in your designated record set is incorrect or if important information is missing, you have the right to request that we correct the records. Your request may be submitted in writing. A request for amendment must provide your reason for the amendment. We could deny your request to amend a record if the information was not created by us; if it is not part of the medical or billing information maintained by us; or if we determine that the record is accurate. You may appeal, in writing, a decision by us not to amend a record.
- You have the right to a list of those instances where we have disclosed medical and billing information about you, other than for treatment, payment, health care operations or where you specifically authorized a disclosure. When you submit a written request, the request must state the time period desired for the accounting, which must be less than six (6)-year period and starting after October 1, 2006. You may receive the list in paper or electronic form. The first disclosure list request in a 12-month period will be provided to you at no cost; other requests will be charged in accordance with our cost to produce the list. We will inform you of the cost before you incur any charges.
- If this Notice was sent to you electronically, you have the right to a paper copy of this Notice.
- You have the right to request that your medical and billing information be communicated to you in a confidential manner, such as sending mail to an address other than your home. You must notify us in writing of the specific way or location for us to use to communicate with you.
- You may request, in writing, that we not use or disclose protected health information about you for treatment, payment or healthcare operations or to persons involved in your care except when specifically authorized by you, or when required by law, or in an emergency. We will consider your request but we are not legally required to accept it. We will inform you of our decision.

All written requests or appeals should be submitted to our office at the address listed on this Notice.

COMPLAINTS

- If you are concerned that your privacy rights may have been violated, or you disagree with a decision we made about access to your records, you may contact our office (listed on the reverse).
- Finally, you may send a written complaint to the U.S. Department of Health and Human Services of Civil Rights. Our office will provide you the address upon request.
- Under no circumstance will you be penalized or retaliated against for filing a complaint.